



# GARLAND

## HOUSING AGENCY

### Reasonable Accommodation Request Form

The U. S. Department of Housing and Urban Development regulations (24CFR 982-316) states: a family that consists of one or more elderly, near-elderly or disabled persons may request approval for a live-in aide to reside in the unit and provide necessary support services for a family member who is a person with disabilities.

The live-in-aide or large amount of medical equipment maybe approved if needed as a reasonable accommodation.

#### DEFINITION

A live-in-aide is defined as: a person who resides with one or more elderly persons or near-elderly persons or persons with disabilities and who:

- 1.) Is determined to be essential to the care and well-being of the persons;
- 2.) Is not obligated for the support of the person; and
- 3.) Would not be living in the unit except to provide the necessary support services

Since housing fund are limited and there are many eligible families on the waiting list we must ensure that a live-in-aide is necessary for the support of a person with a disability.

#### A. HOUSEHOLD INFORMATION

Name of Head of Household: (please print) \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Social Security Number: \_\_\_\_\_ Telephone #: ( ) \_\_\_\_\_

1. Name of disabled family member \_\_\_\_\_
2. What specific accommodation are you requesting? (See the definitions above) \_\_\_\_\_
3. Date Physician medically prescribed the accommodations? \_\_\_\_\_

#### B. REQUEST FOR LIVE-IN-AIDE

1. If you are requesting a live-in-aide, complete the following regarding the person to provide the live-in-care:

Name: \_\_\_\_\_ SSN \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Number of members in live-in-aide's household? \_\_\_\_\_

2. What are the qualifications of the Live-in-Aide that will provide the needed care? \_\_\_\_\_
3. Is the Live-In-Aide needed (circle one) a. permanently or b. temporary? If temporary, state how long needed \_\_\_\_\_

4. What are the duties and responsibilities of the Live-In-Aide? \_\_\_\_\_

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**C. REQUEST FOR REASONABLE ACCOMMODATION FOR MEDICAL EQUIPMENT**

1. If you are requesting reasonable accommodation for medical equipment, please state the type of equipment needed:

a. \_\_\_\_\_ b. \_\_\_\_\_

c. \_\_\_\_\_ d. \_\_\_\_\_

**D. REQUEST FOR REASONABLE ACCOMMODATION FOR OTHER REASONS**

1. Describe the accommodations needed? \_\_\_\_\_

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**E. PRESCRIBING PHYSICIAN'S NAME AND ADDRESS**

Name: \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Note: Prior to approval, all required eligibility and screening of the live-in-aide will be completed including criminal acts in connection with any federal housing program, documentation that the live-in-aide left their previous residence in good standing and that the owner of the unit has approved the live-in-aide.**

**WARNING:** Section 101 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency.

I certify that my request and the information I have provided is true and complete to the best of my knowledge and belief.

X \_\_\_\_\_  
Signature of Head of Household

**FOR OFFICE USE ONLY**

\_\_\_\_\_ **Accommodation granted**

\_\_\_\_\_ **Accommodation Denied: Reason** \_\_\_\_\_

**Recommendations:** \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Garland Representative**

\_\_\_\_\_  
**Date**